

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>RITTENHOUSE SENIOR LIVING OF VALPARAISO</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1300 VALE PARK RD</b> <b>VALPARAISO, IN 46383</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00211673.</p> <p>Complaint IN00211673 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 20 and 21, 2016</p> <p>Facility number: 012181 Provider number: 012181 AIM number: NA</p> <p>Residential Census: 100</p> <p>Sample: 8</p> <p>Rittenhouse of Valparaiso was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00211673.</p> <p>QR was completed by 99993 on 10/24/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE